

2011

# CPC Certification Study Guide

Deborah Grider

G. John Verhovshek



CMS annually publishes Physician Fee Schedule (PFS) information on its website ([www.cms.hhs.gov/Physician-FeeSched/](http://www.cms.hhs.gov/Physician-FeeSched/)) and posts the formula for calculating PFS payment amounts. The published formula for calculating the 2010 PFS payment amount is:

PE = Physician Expense

MP = Malpractice

GPCI = Geographic practice cost index (this is used to realize the varying cost based on geographic location)

CF = Conversion Factor (this is a fixed dollar amount used to translate the RVUs into fees)

$$2010 \text{ Non-Facility Pricing Amount} = [(Work \text{ RVU} * Work \text{ GPCI}) + (Transitioned \text{ Non-Facility PE RVU} * PE \text{ GPCI}) + (MP \text{ RVU} * MP \text{ GPCI})] * (CF)$$

$$2010 \text{ Facility Pricing Amount} = [(Work \text{ RVU} * Work \text{ GPCI}) + (Transitioned \text{ Facility PE RVU} * PE \text{ GPCI}) + (MP \text{ RVU} * MP \text{ GPCI})] * CF$$

The published conversion factor for June 1, 2010 - November 30, 2010 is \$36.8729. RVUs and the conversion factor may change from year to year and may be updated throughout the year based on legislative changes.

#### RVU table for E/M codes New Patient and Established Patients (99201–99215)

HCPCS	DESCRIPTION	WORK RVU	TRANSITIONED	TRANSITIONED	MP RVU
			NON-FACILITY PE RVU	FACILITY PE RVU	
99201	Office/outpatient visit, new	0.48	0.57	0.18	0.03
99202	Office/outpatient visit, new	0.93	0.88	0.35	0.06
99203	Office/outpatient visit, new	1.42	1.19	0.5	0.1
99204	Office/outpatient visit, new	2.43	1.61	0.82	0.17
99205	Office/outpatient visit, new	3.17	1.91	1.04	0.2
99211	Office/outpatient visit, est.	0.18	0.34	0.06	0.01
99212	Office/outpatient visit, est.	0.48	0.57	0.17	0.03
99213	Office/outpatient visit, est.	0.97	0.79	0.32	0.05
99214	Office/outpatient visit, est.	1.5	1.14	0.49	0.07
99215	Office/outpatient visit, est.	2.11	1.45	0.7	0.10

Table 1.2

Source: CMS ([www.cms.gov](http://www.cms.gov)); PPRVU10\_Oct\_PCT22\_v6.

**Note:** In 2006, CMS announced proposed changes to the methodology of calculating the physician fee schedule. A four-year transition was established to improve RVUs with full implementation by 2010.

Using the word parts for translation, you will find the approximate meaning of the complete medical term.

### Example:

The word “cardiomyopathy” can be broken down to find its meaning:

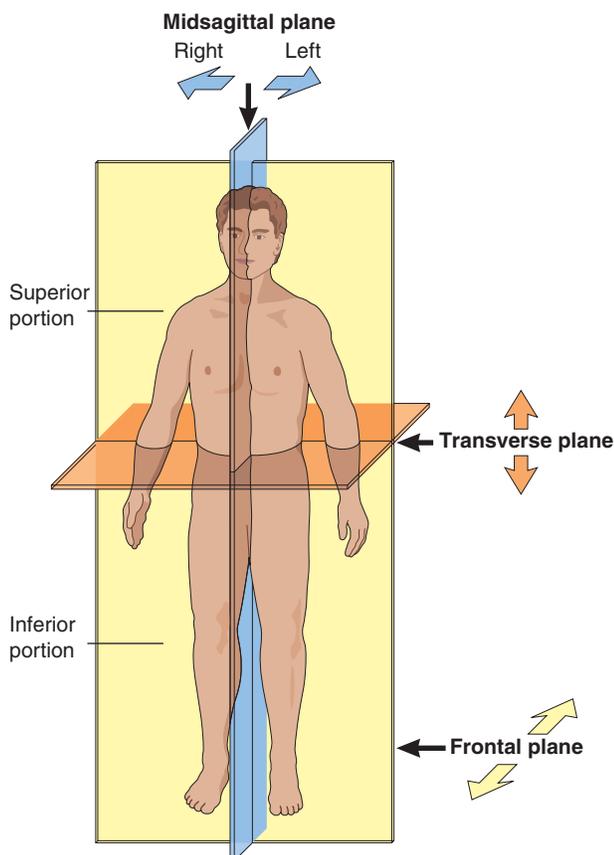
cardi/o—heart  
my/o—muscle  
pathy—disease

Cardiomyopathy is a diseased heart muscle.

## Anatomical Positions and Planes

The standard body position is considered the “anatomical position.” The anatomical position is an upright, face-forward position with the arms by the side and palms facing forward. The feet are parallel and slightly apart.

### Anatomical Planes and Directions



Source: Delmar/Cengage Learning.

Based on the anatomical position, the following directional terms are pertinent to understanding medical documentation:

**Anterior (ventral)**—Toward the front of the body.

**Posterior (dorsal)**—Toward the back of the body.

**Medial**—Toward the midline of the body.

**Lateral**—Toward the side of the body.

**Proximal**—Nearer to the point of attachment or to a given reference point.

**Distal**—Farther from the point of attachment or from a given reference point.

**Superior (cranial)**—Above; toward the head.

**Inferior (caudal)**—Below; toward the lower end of the spine.

**Superficial (external)**—Closer to the surface of the body.

**Deep (internal)**—Closer to the center of the body.

For radiological studies on the body, the body is often virtually cut along a flat surface called a plane. The most frequently used planes include:

**Sagittal**—Cuts through the midline of the body from front to back and divides the body into right and left sections.

**Frontal (coronal)**—Cuts at a right angle to the midline cut, from side to side, and divides the body into front (anterior) and back (posterior) sections.

**Transverse (horizontal)**—Cuts horizontally through the body and separates the body into upper (superior) and lower (inferior) sections.

## Structure of the Human Body

The structure of the human body falls into four categories:

1. The cell is the basic unit of all living things. Human anatomy is composed of cells that vary in size and shape according to function.

**[ ]** Slanted brackets are used to indicate multiple codes are required.

### Example:

Diabetes, diabetic 250.0x  
cataract 250.5 [366.41]

In this example, two codes are required: 250.5x *Diabetes with ophthalmic manifestations*, which requires a fifth digit to indicate the type of diabetes and whether it is controlled or uncontrolled; and 366.41 *Diabetic cataract*.

**( )** Parentheses are used to enclose supplementary words that may be present or absent in the statement of a disease or procedure, without affecting the code number to which it is assigned.

### Example:

Cyst (mucus) (retention) (serous) (simple)

**:** The colon is used in Volume 1 (tabular list) after an incomplete term that needs one or more of the modifiers that follow to make it assignable to a given category.

### Example:

553.21 Incisional  
Hernia:  
postoperative  
recurrent, ventral

## Other Conventions

**Boldface** Boldface type is used for all codes and titles in the Tabular List.

*Italicized* Italicized type is used for all exclusion notes and to identify codes that should not be used for describing the primary diagnosis.

**EXCLUDES** Terms following the excludes note are to be reported with a code from another

category. Following the excludes note, there is a list of the excluded conditions/diseases with codes referenced to provide direction to the proper code. Attention is drawn to these codes by placing the word excluded in a box and using italics to draw attention to them.

### Example:

599.0 Urinary tract infection, site not specified  
**EXCLUDES** candidiasis of urinary tract (112.2)  
urinary tract infection of newborn (771.82)

In this example, we see that if the patient has candidiasis of the urinary tract, the correct code is 112.2. The use of “excludes” in the tabular section alerts the coder there is a more appropriate code for a specific condition than is listed in the current category.

### Testing Technique

Highlight the conditions following the “excludes” note. This will help draw your eye to the excluded conditions while you are taking your exam.

**INCLUDES** This note appears immediately under a three-digit code title to define further, or to give an example of the contents of, the category.

### Example:

280 Iron deficiency anemias  
anemia:  
**INCLUDES** asiderotic  
hypochromic-microcytic  
sideropenic

### Use additional code

This instruction signals the coder an additional code should be used, if the information is available, to provide a more complete picture of the diagnosis.

**Example:**

282.42 Sickle-cell thalassemia with crisis  
 Sickle-cell thalassemia with vaso-occlusive pain  
 Thalassemia Hb-S disease with crisis

Use additional code for the type of crisis, such as:  
 acute chest syndrome (517.3)  
 splenic sequestration (289.52)

In this example, an additional code is reported to identify the type of crisis. When sequencing codes, the codes listed under the “use additional code” is secondary to the code in the category. If a patient has a sickle-cell thalassemia crisis with acute chest syndrome, the proper codes in the correct sequence are 282.42, 517.3.

**Code first**

Used in categories not intended to be the principal diagnosis. These codes are also written in italics with a note. The note requires that the underlying disease (etiology) be recorded first and the particular manifestation be recorded second. This note will appear only in the Tabular List.

**Example:**

284.2 Myelophthisis  
 Leukoerythroblastic anemia  
 Myelophthisic anemia

Code first the underlying disorder, such as:  
 Malignant neoplasm of breast (174.0-174.9,  
 175.0-175.9)  
 Tuberculosis (015.0-015.9)

The “code first” indicates the codes listed should be sequenced first. If a female patient with breast cancer is diagnosed with myelophthisis, the proper codes and sequencing are 174.9, 284.2.

**Use additional code, if applicable**

The causal condition note indicates that this code may be assigned as a diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, the code should be sequenced as the principal diagnosis.

**Example:**

416.2 Chronic pulmonary embolism

Use additional code, if applicable, for associated long-term (current) use of anticoagulants (V58.61)

In this example, report code V58.61 in addition to 416.2 only if it is documented that the patient has been taking anticoagulants for an extended period.

**Combination code**

In such case, a single code used to classify two diagnoses, a diagnosis with an associated secondary process (manifestation), or a diagnosis with an associated complication.

**Example:**

If a patient has nausea and vomiting, it is reported with one code that describes both symptoms.

Vomiting 787.03  
 with nausea 787.01

In this example, 787.01 is reported for a patient who has symptoms of nausea and vomiting. It would be inappropriate to report two codes when one code describes the patient’s signs and symptoms.

**Eponym**

This is a disease or syndrome named after a person. An example is Lou Gehrig’s disease, which also is known as amyotrophic lateral sclerosis (ALS). It was named after a famous baseball player who was diagnosed with the disease.

**Modifiers**

Essential modifiers are subterms that are listed below the main term in alphabetical order, and are indented two spaces. Nonessential modifiers are sub terms that follow the main term and are enclosed in parentheses; they can clarify the diagnosis but are not required.

**Notes**

Used to define terms, clarify information, or list choices for additional digits.

**Other**

“Other” or “other unspecified” codes (usually with

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## Chapter Review Questions

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- 1. The term “pneumomediastinum” describes what condition?**
  - A. Inflammation of the mediastinum
  - B. Puncture of the alveoli of the lungs
  - C. Presence of a cyst or tumor in the mediastinum
  - D. The presence of air in the mediastinum
- 2. A respiratory disease characterized by overexpansion and destruction of the alveoli identified as:**
  - A. Cystic fibrosis
  - B. Pneumoconiosis
  - C. Emphysema
  - D. Respiratory distress syndrome
- 3. A 35-year-old was diagnosed with stage I ductal carcinoma *in situ* in her right breast. She underwent a localized biopsy of sentinel lymph and axillary nodes in her right breast. An incision was made with the scalpel, once the glandular tissue of the breast was intercepted; dissection was carried down through the skin and subcutaneous tissue. One to two centimeters of the breast tissue was dissected free to the lymph node. The incision was carried deep to the right axilla and two sentinel and non-sentinel lymph nodes were identified and excised. What procedure code should be used?**
  - A. 38525
  - B. 38570
  - C. 38500
  - D. 38505
- 4. A 29-year-old female in the hospital who has full blown AIDS has been put on a ventilator due to her weakness and dyspnea. The physician suspects she has pneumonia and performs a thoracoscopy. The contents of the chest cavity are inspected with an endoscope and multiple areas of consolidation are seen in the right lung and biopsied. Pneumocystis carinii pneumonia is diagnosed. The correct CPT® and ICD-9-CM codes are:**
  - A. 32601, 486, 042
  - B. 32602, 042, 136.3
  - C. 32606, 042, 136.3, V08
  - D. 32650, 136.3, 042

## 10. Operative Report #2

**Preoperative Diagnosis:** Recurrent right-sided epistaxis.

**Postoperative Diagnosis:** Recurrent right-sided epistaxis.

**Procedure:** Right maxillary antrostomy with biopsy and right internal maxillary artery ligation.

**Complications:** None.

**Estimated Blood Loss:** 5 cc

**History:** This is a 71-year-old male with a problem with recurrent epistaxis. He did have a widely deviated nasal septum which I did repair about a month ago, but despite that he is still having one to two nosebleeds a week which are fairly severe. Because of that I did recommend to him that he undergo an internal maxillary artery ligation. The procedure, risks, and benefits were discussed with him in the office and he is agreeable to the surgery.

**Description of Procedure:** The patient was identified in the preoperative waiting area and taken back to the operating room where he underwent anesthesia. Approximately 3 cc of 1% Lidocaine with epinephrine were injected into the right inferior turbinate, the right middle turbinate, and the uncinate process on the right. Afrin-soaked pledgets were then placed on that side of the nose and left there for about five minutes. These were then removed and a 0 degree nasal endoscope was placed on the right side of the nose. I used a Freer to medialize the middle turbinate and then I was able to locate the maxillary ostia on the right side. Following this posterior, I did end up using a thru-cut forceps to widen the opening slightly to get me closer to the posterior wall of the maxillary sinus on the right side. Tissue was sent away for pathology. It did appear to be inflamed. I then used the Freer to raise a mucosal flap from the lateral wall. Once I was able to get to the posterior portion of the maxillary sinus, I was immediately able to see the right internal maxillary artery. I did isolate this both in front of, above, and below the artery itself. I was able to place three clips on the vessel itself. There appeared to be good hemostasis. The 0 degree nasal endoscope was removed. I did inspect the rest of the right side of the nose and left side of the nose. There appeared to be a few prominent blood vessels, namely on the lateral side of the nose, involving the inferior turbinate. I did cauterize these areas giving them good hemostasis. Again, just a small amount of blood was suctioned from the nasopharynx.

The patient was awakened and taken to the postoperative recovery room in stable condition.

**What are the CPT® and ICD-9-CM codes for this service?**

## Introduction

This chapter will review the cardiovascular system. Codes relevant to this system are found in several sections of the CPT® manual (specifically surgery, radiology, and medicine), and throughout the ICD-9-CM (primarily chapter 7) and HCPCS Level II manuals.

Objectives for this chapter are:

- Master anatomical concepts necessary to understand the cardiovascular system
- Define key terms, and recognize common eponyms and acronyms

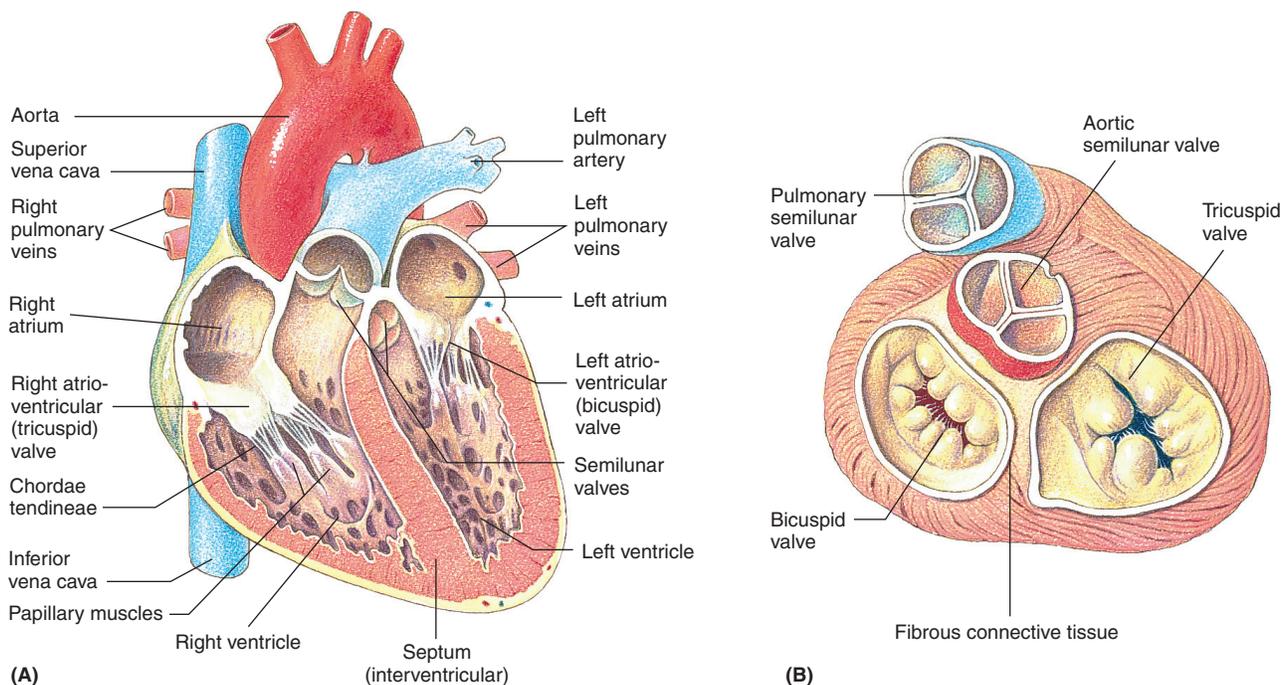
- Explain the most common pathologies that effect this system
- Understand relevant procedures and how to apply CPT® codes that represent them
- Introduce ICD-9-CM and HCPCS Level II codes and guidelines as they apply to this systems

## Anatomy and Medical Terminology

The cardiovascular system is comprised of the heart, arteries, and veins.

## The Heart

### The Heart



Source: Delmar/Cengage Learning.

Using the results from tables A, B, and C, complete the table below to determine the overall MDM level. The column with two items selected or the column in the middle will be the level for the MDM.

**Table F: Medical Decision Making (MDM)**

Final Result of Tables C, D, E = Level of Medical Decision Making (MDM)					
Table C	Number of diagnosis/treatment options	1	2	3	4
Table D	Amount of data reviewed/ordered	1	2	3	4
Table E	Level of risk	Minimal	Low	Moderate	High
MDM Level		Straightforward	Low	Moderate	High

Using the results from the Tables of History, Exam, and MDM, we will complete the table below resulting in the office visit level of our patient.

**Table G: Established Patient Office Visit**

Established patient office visit table				
History (Table A)	Problem focused	Expanded problem focused	Detailed	Comprehensive
Exam (Table B)	Problem focused	Expanded problem focused	Detailed	Comprehensive
MDM (Table D)	Straightforward	Low	Moderate	High
Level of Visit	99212	99213	99214	99215

Two of three key components are needed to make established patient level visit. The level for the visit is 99213.

### Contributory Factors to E/M Service Leveling

Contributory factors include counseling, coordination of care, and nature of the present problem. The first two factors are important in E/M, but are not required for each visit. The nature of the presenting problem is considered as the disease, illness, condition, injury, symptom, signs, finding, complaint, or other problem with or without a diagnosis.

### Counseling

Counseling may be included during the visit of a patient and reflect such topics as weight control (to cite just one example). The provider may counsel the patient on the adverse effects of smoking and second hand smoke. He also may prescribe smoking cessation.

### Nature of Presenting Problems

Nature of a presenting problem includes five types:

- Minimal: a problem that may not require the presence of the physician; however, services provided are under the physician’s supervision.
- Self-limited or minor: does not permanently alter health status, and with management and compliance has an outcome of “good.”